Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVIORAL HEALTH AND ASSOCIATES
5555 FREDERICKSBURG RD #102
SAN ANTONIO TX 78229

Carrier's Austin Representative Box
Box Number 45

MFDR Date Received
DECEMBER 11, 2013

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-14-1073

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A 'Peer Review' is an opinion of an evaluator Rule 134.600 **DOES NOT** state that claims can be denied as not medically necessary based on an opinion or NOT understanding the relation of the medical necessary treatment to the compensable injury of a medical evaluator whom may or may not have had all of the patient's medical records for review at the time he/she conducted the peer review nor does it state anywhere that just because the payer deems the services were not medically necessary they can deny payment on these services.""

Amount in Dispute: $28.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed a review of the disputed charges and claim file which revealed that the necessity for case management activity for this injured worker has not been substantiated. The claim review revealed that the injured employee at the time of this service is only receiving medications which are being managed by Dr. Jackie Stephenson. The documentation further states continue medication management per Dr. Stephenson. Contested case hearing decision and will be requested for review. There is not a documented change in the injured worker's health condition to substantiate this conference nor does it appeal coordination of return to work was the focus of this conference as indicated by Rule §134.202(e)(A-D)."

Response Submitted by: STATE OFFICE OF RISK MANAGEMENT

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2012	Professional Services	$28.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §133.100 sets out the procedures for health care under the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 17, 2013
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - T14 – Appeal/Reconsideration based on medical necessity.
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.305(a)(5) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." In accordance with 28 Texas Administrative Code §133.307(f)(d)(B) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. 28 Texas Administrative Code §137.100 Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		September 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.